Health History Form

In order for you to attend classes at Washington County Community College, you must complete both sides of this form and return to Student Services **BEFORE CLASSES BEGIN.** If you have any questions regarding this form, please call Student Services at 207 454-1000.

TO BE FILLED OUT BY STUDENT: Date:_________________________

Name:__________________________ S. S. #:_______________________ Date of Birth:___________________________

Address:________________________________ City:_________________________State:_____________Zip:____________

Phone:____________________Program of Study:___________________________Starting Date:_______________________

Person to Contact in Case of Emergency Home Address Home Telephone

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Family Physician Address Telephone

Maine state law requires that all entering students furnish proof of immunization against measles, mumps, rubella, and diphtheria/Tetanus. Students shall have a physician, nurse or other student healthcare provider complete and sign this form or present a copy of an immunization certificate in its place. The certificate must contain the dates immunizations were given as well as the signature of the healthcare provider. **Students born before January 1, 1957 are exempt from the proof for measles, mumps, and rubella.**

TO BE FILLED OUT AND SIGN BY HEALTHCARE PROVIDER

(The above vaccines may also be given in several different combined preparations. M/R Vax (for measles and rubella); MMR Vax (for measles, mumps, and rubella), or Biovax (for rubella and mumps)

Dose #1 Dose #2

MEASLES __/__/__ __/__/__ MEASLES (RUBEOLA): Two doses of measles vaccine administered after the student was 1 year old. Any child who was immunized prior to January 1, 1968, with inactivated measles vaccine (Pfizervaz Measles K) must be re-immunized.

MUMPS __/__/__ __/__/__ MUMPS: Two doses of mumps vaccine administered after the student was 1 year old.

RUBELLA __/__/__ __/__/__ RUBELLA (GERMAN MEASLES): Two doses of Rubella vaccine administered after the student was 1 year old and after January 1, 1969.

MENINGOCCAL __/__/__ MENINGOCCAL: vaccine to each newly entering **student who plans to live in the dorms.**

DT, DTP, or TD __/__/__ DIPHTHERIA/TETANUS: Within the last ten years prior to enrollment and by the tenth Anniversary date while enrolled.

Student's signature:____ Date:___________________________

Healthcare Provider's title and signature_______________________________________

Personal History

PLEASE ANSWER ALL QUESTIONS ABOUT YOUR HEALTH. Please comment on "yes" answers on a separate sheet of paper.

Height: ___________ Weight: _________

DO YOU HAVE?	Yes	No	Do you have?	Yes	No	Do you have?	Yes	No
Fainting			Chronic cough			Allergies:		
Recurring Headaches			Pain-pressure in Chest			Foods Drugs Others		
Seizure Disorder or Convulsions			Heart disease or High blood pressure			Disease or injury Of		
Head injury with unconsciousness			Diabetes			Depression or Recurring anxiety		
Eye disease or Color blindness			Hypoglycemia			Chicken Pox		
Asthma			Menstrual problems			Insomnia		
Tuberculosis			Blackout problems					

Family History

	Age	State of Health	Age at Death	Cause of Death
Father				
Mother				
Brother(s)/Sister(s)				

Other Important Questions

Please comment on all "yes" answers. Your answers will remain confidential.

Yes	No

1. Have you had any serious injury, or been hospitalized for medical, surgical or psychiatric reasons Within the past five years? (if yes, please give reason(s) and duration.)

2. Is your physical activity currently restricted, or has it been restricted in the past five years? (If yes, please give reason and duration.)

3. Are you currently on any medication? Please specify names, if it is a prescription or over the counter and dosages below:

Rev.: 2/1/08